To the Editor—A harm reduction approach to breastfeeding in the context of maternal human immunodeficiency virus (HIV) was a refreshing perspective to consider and we congratulate Levinson et al [1] on this provocative suggestion. Harm reduction as a counseling philosophy is in consonance with the World Health Organization guidelines, as both focus on informed parental decision making [2]. Choices regarding infant feeding are highly personalized for parents, and we must not negate that these choices
remain personal for women with HIV despite the limitations imposed by transmission risks and national guidelines. As members of a working group devoted to this topic in Ontario, Canada, which organized the referenced forum of >50 women in Toronto, we worry that the application of a harm reduction approach is not an easy task and want to add to this discussion by raising some points that went unmentioned in the original article. We believe that discussions and counseling about infant feeding options in the context of maternal HIV infection are often overlooked entirely, with formula feeding being a foregone conclusion in our setting; this oversight needs to be addressed, first and foremost. We also worry that by neglecting the inherent challenges in implementing a harm reduction approach, further tensions between service providers and community members who advocate breastfeeding for mothers with HIV could arise, and possible harm related to HIV transmission may increase.

The successes of harm reduction, particularly related to HIV transmission, have been profound, but difficulties in implementation continue to impede uptake. Arguments against harm reduction have been largely premised on ideological, moral, and legal grounds [3]. Such objections are likely to be a major impediment and should be explored with all relevant stakeholders before a harm reduction approach to breastfeeding can be considered. In the climate of criminalization of HIV nondisclosure in Canada, Canadian mothers need to know what risk they are taking in choosing to breastfeed in terms of the law. Unfortunately, the law is not always informed by science [4]. Guidance from the United Kingdom recommending against automatic child protection service involvement when mothers with HIV choose to breastfeed while virologically suppressed on antiretroviral therapy (ART) [5] provides a valuable starting point. Canadian guidelines have followed suit, in the hopes of opening lines of clinician–parent discussion using a harm reduction approach [6].

There is also an ethical difference between the harm reduction strategies of the past involving consenting adults making decisions on what is an acceptable level of risk for themselves, and the one under discussion here, when a parent is making a decision of what is acceptable risk for their child. There is an inherent tension between the needs, desires, and rights of mothers and the rights of their child. Clinicians are bound to support parents’ decision-making, but are equally bound to ensure the safety of such decisions for a child both legally and ethically. Our interdisciplinary team aims to address this tension by encouraging discussion of the priorities of both child and mother/parent. We do not believe the issue of breastfeeding can be broached without both sides being considered. As clinicians, we are tasked with providing evidence-based counseling on risk of transmission to ensure an informed decision. The lack of clarity regarding HIV transmission risk via breastfeeding in our context is due to the relative North American data void on this topic. It is difficult, and likely inappropriate, to generalize data from resource-limited settings to clients we see in Canada (or the United States). Women and children face a very different burden of disease and health service availability in such settings, and infants’ risk of HIV infection must be balanced against the health risks of not breastfeeding [7–9]. Similarly, although preliminary data suggest that extensive exposure to antiretrovirals through breast milk in HIV-uninfected infants is safe, we still have only limited data on the long-term outcomes of these children, making counseling regarding actual risk difficult [10].

Breastfeeding practices in Canada may also differ substantially from the circumstances described in previous studies; for example, women may breastfeed only in social situations, potentially exposing the infant to a higher transmission risk associated with mixed feeding.

Our group is finalizing a systematic review exploring risk of perinatal HIV transmission through breastfeeding among women who are on ART who are virologically suppressed. We hope the results might give us a better estimate overall that can assist clinicians in their counseling and contribute to this discussion. Further exploration of these issues is needed, and we welcome the discussion that will be required to move this important issue forward for the benefit of mothers with HIV and their infants.

Note

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V. Logan Kennedy,1 Mona R. Loutfy,1,2 and Jason Brophy3,4; for the Ontario HIV Infant Feeding Working Group

1Women’s College Hospital, Women’s College Research Institute, 2Faculty of Medicine, University of Toronto, Toronto, 3Division of Infectious Diseases, The Children’s Hospital of Eastern Ontario, and 4Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada

References


Correspondence: V. Logan Kennedy, MN, BScN, RN, 790 Bay St, Ste 736, Toronto, ON M5G 1N8, Canada (logan.kennedy@wchospital.ca).

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